DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/30/10

PRINTED: 09/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445445	A. BUILDING _____ B. WING _____	09/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY MANOR INC	120 PITCOCK LANE CELINA, TN 38551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dignity was maintained for three residents (#7, #17, and # 18) of eighteen residents reviewed. The findings included: Observation of the dining room on September 14, 2010, at 11: 40 a.m., revealed resident # 7 and resident #17 seated at the same table. Continued observation revealed all other residents in the dining area had received the lunch trays at 11:50 a.m., and were eating. Further observation revealed resident #7 and #17 did not receive a tray until 12:05 p.m. Interview with the Director of Nursing on September 15, 2010, at 4:00 p.m., in the Administrator's office, confirmed the residents had a delay in receiving their lunch trays. Observation of a medication administration on September 13, 2010, at 3:30 p.m., revealed LPN #2 (Licensed Practical Nurse) administering medication to resident #18 through a PEG (percutaneous endoscopic gastrostomy) tube. Continued observation revealed LPN #2 did not provide privacy for the resident prior to administering the medication.	F 241	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. F241 1. Lunch trays were provided to Residents #7 and #17 by the Director of Nursing and Dietary Manager on Sept. 14, 2010 At 12:05 pm. The Director of Nursing immediately closed the blinds during the administration of the medications for Res #18 so that the resident did have privacy for the remainder of the medication administration process. The licensed practical nurse was immediately inserviced by the Director of Nursing on 9/13/10 on providing privacy to residents during medication administrations.	Completion Date 9/25/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul Bosse	Administrator	9/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Boone — TITLE: Administrator — (X6) DATE: 9/29/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Boone	Administrator	9/29/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Boss	Administrator	9/29/10

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F 241	Continued From page 1 Interview with the LPN #2 on September 13, 2010, at 3:50 p.m., in the hallway, confirmed privacy was not provided for the resident prior to administering the medication.	F 241		
F 252 SS=C	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT . The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a clean and sanitary environment. The findings included: Observation during the initial tour on September 13, 2010, at 9:40 a.m., of the shower room on the 300 hallway, revealed several areas of brown debris on the floor. Interview with LPN #1 (Licensed Practical Nurse) at the time of observation confirmed the brown debris needed to be cleaned off the floor. Observation on the initial tour on September 13, 2010, at 9:45 a.m., revealed in room #310 the bathroom floor had several areas that were brown stained. Interview with the DON (Director of Nursing) on	F 252	F252 1. Rust remover was obtained and the brown areas were removed by the Housekeeping Supervisor on 9/14/10. 2. An assessment of all flooring areas was conducted by the Housekeeping Supervisor on 9/14/10 to ensure that no other areas were affected. 3. The Housekeeping Department was inserviced on 9/23/10 by the Administrator regarding proper cleaning techniques to ensure a clean and sanitary environment. 4. All flooring areas will be monitored by the Housekeeping Supervisor daily for five days. The flooring will then be monitored by the Housekeeping Supervisor two times per week for three months to ensure that all areas	Completion Date 9/25/2010

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F 241	Continued From page 1 Interview with the LPN #2 on September 13, 2010, at 3:50 p.m., in the hallway, confirmed privacy was not provided for the resident prior to administering the medication.	F 241	are properly cleaned and the environment is sanitary or until 100% compliance is achieved. All results will be reported monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 252 SS=C	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a clean and sanitary environment. The findings included: Observation during the initial tour on September 13, 2010, at 9:40 a.m., of the shower room on the 300 hallway, revealed several areas of brown debris on the floor. Interview with LPN #1 (Licensed Practical Nurse) at the time of observation confirmed the brown debris needed to be cleaned off the floor. Observation on the initial tour on September 13, 2010, at 9:45 a.m., revealed in room #310 the bathroom floor had several areas that were brown stained. Interview with the DON (Director of Nursing) on	F 252		

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F 252	Continued From page 2 September 15, 2010, at 8:00 a.m., in the bathroom of room #310, confirmed the brown stains on the bathroom floor. Observation on September 13, 2010, at 2:10 p.m. of the whirlpool room on the 300 hallway revealed the floor had areas of brown debris stains. Interview with the DON on September 13, 2010, at 2:30 p.m., in the whirlpool room, confirmed the floor had areas of brown debris.	F 252	F280 1. The care plan for resident # 2 was immediately updated by the Minimum Data Set Coordinator to reflect the resident's transfer needs on 9/15/10. 2. An audit of all resident care plans was conducted by the Director of Nursing, Minimum Data Set Coordinator, and the Staffing Coordinator on 9/15/10 to assess for problem identification and appropriate intervention identification. 3. The Minimum Data Set Coordinator was inserviced about the care planning process by the Director of Nursing on 9/15/10. 4. Completed admission, quarterly, significant change and annual assessments will	Completion Date 09/25/2010
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		

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F 280	Continued From page 3 by: Based on medical record review and interview the facility failed to update a care plan for one (#2) of eighteen residents reviewed. The findings included: Resident #2 was admitted to the facility on May 11, 2010, with diagnoses including Congestive Heart Failure, Diabetes, Aftercare for Fracture of Leg, Difficulty in Walking, and Esophageal Reflux. Medical record review of the Minimum Data Set dated August 7, 2010, revealed the resident had no deficit with memory, had modified independence for decision making, and required extensive assist with two person assist for transfers and ambulation. Review of the care plan updated August 10, 2010, revealed the care plan did not address the need for the resident to require extensive assistance for transfers and ambulation. Interview with the DON (Director of Nursing) on September 15, 2010, at 1:15 p.m., in the DON's office, confirmed the care plan did not address the resident's need for extensive assistance for transfers and ambulation.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	F281 1. The order was immediately clarified with the attending MD on 9/14/10 by the Director of Nursing who clarified that the appropriate order was being administered to resident #9. Resident # 9 was assessed on 9/14/10 by the Director of Nursing and noted to have no adverse outcomes. Resident # 9 was assessed by his physician on 9/25/10 who again confirmed that the appropriate order was being given. The LPN was immediately inserviced on 9/14/10 by the Director of Nursing regarding policy and procedure of processing mental health recommendations.	Completion Date 09/25/2010

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F 281	Continued From page 4 by: Based on medical record review, observation, and interview, the facility failed to follow a physician's order for one (#9) of 18 residents reviewed. The findings included: Medical record review revealed Resident #9 was admitted to the facility in May 2006, with diagnoses including Parkinson's Disease, Dementia with Behavior Disturbance, Depression, and Chronic Obstructive Pulmonary Disease. Medical record review revealed the consulting Nurse Practitioner (NP) for psychological services documented the resident's status as "Acutely Unstable" on August 3, 2010, and on the following visit on August 9, 2010, stated, "Inadequate response...staff reports...still has episodes of agitation..." Further review of the August 9, 2010, consult visit revealed the NP recommended Seroquel 50mg at HS (bedtime) be increased to BID (twice a day) and documented, "Antipsychotic medication recommendations are to relieve patient distress and decrease opportunity for harm and to increase functional capacity." Further review of the August 9, 2010, NP's consult note revealed a space provided for the physician to accept or not accept the recommendations and a place for the physician's signature if the recommendation was accepted. Medical record review revealed the physician had accepted and signed the August 9th recommendation on August 15, 2010. Medical record review of the resident's August and September 2010, Medication Administration	F 281	2. All residents receiving psychotropic medications were audited on 9/14/10 by the Minimum Data Set Coordinator to ensure that all appropriate orders were being administered. 3. The Social Services Department consisting of the Director and Marketing/Admissions Director were inserviced on the established system for expediting mental health medication recommendations into physician's orders on 9/14/10 by the Administrator. All licensed nurses were inserviced on 9/15/10, 9/17/10, 9/23/10, and 9/24/10 by the Director of Nursing regarding the policy and procedure of processing mental health recommendations. 4. All residents who are receiving mental health services were audited to ensure that appropriate MD orders are in place for all approved recommendations.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445445	A. BUILDING _____ B. WING _____	09/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY MANOR INC	120 PITCOCK LANE CELINA, TN 38551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 Records revealed the increase of the Seroquel to twice a day had not been initiated. Interview with the registered nurse (RN) Staff Coordinator on September 14, 2010, verified the facility's nursing staff had reviewed the physician's recommendation on August 24, 2010, but had not transcribed the doctor's order to the facility's order system for the pharmacy and nursing staff to follow. Interview with the consulting NP for psych services on September 14, 2010, at 3:30 p.m., in the social services office, verified there was an established system for expediting medication recommendations into a physician's order for residents with acute psychological problems. Interview with the RN/Staff Coordinator on September 14, 2010, at 3:50 p.m., in the social services office, verified the expedited system was not used for resident #9. Interview confirmed there was a fifteen day interval from the time the recommendation was made and when the nursing staff reviewed the order received back from the physician. Interview confirmed the physician's order was not followed.	F 281	Fifteen charts per month will be audited for three months to monitor compliance or until 100% compliance is achieved. All verbal orders from physicians will be audited weekly for three months by the Director of Nursing to monitor for timely approvals and signatures. All results will be reported monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor. F315 1. CNA #1 and CNA #2 were immediately inserviced on 9/14/10 regarding proper pericare procedures by the Regional Director of Clinical Services. The Director of Nursing assessed Resident # 7 after each occurrence on 9/14/10 and no adverse affects were noted.	Completion Date 09/25/2010
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	Continued From page 6 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide appropriate incontinence care for one resident (#7) of eighteen residents reviewed. The finding included: Resident #7 was admitted to the facility on September 18, 2007, with diagnoses including Vascular Dementia, Alzheimer's Disease, Hypertension, Chronic Obstructive Pulmonary Disease and Depressive Psychosis. Medical record review of the Minimum Data Set dated August 28, 2010, revealed the resident had short and long term memory deficit, severely impaired decision making skills, required extensive assist for transfers, was nonambulatory, and was incontinent of bowel and bladder. Observation on September 14, 2010, at 10:45 a.m., in the resident's room, revealed CNA #1 (certified nursing assistant) providing incontinence care. Continued observation revealed the CNA #1 removed the wet brief and placed a dry brief on the resident without cleaning the perineal area. Interview with the CNA #1 on September 14, 2010, at 10:55 a.m., in the hallway, confirmed	F 315	2. Random pericare observations were conducted by the Director of Nursing and Staffing Coordinator on 9/14/10, 9/15/10, and 9/16/10 to observe for additional areas that may need to be addressed with proper pericare procedures. 3. The licensed nurses and the nursing assistant staff was inserviced on pericare procedures by the Director of Nursing and/or the Regional Director of Clinical Services on 9/14/10 and 9/15/10 and as well as 9/17/10 and 9/23/10 by the Director of Nursing and Staffing Coordinator. 4. Pericare observations will be conducted randomly by the Staffing Coordinator on nursing assistants for a total of ten random observations for one week to ensure appropriate incontinence care is being provided. Then five random pericare observations on all three random shifts will be conducted each week for three months or until 100% compliance is achieved by the Staffing Coordinator. Random	

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F 315	Continued From page 7 appropriate incontinence care had not been provided. Observation on September 14, 2010, at 3:30 p.m., in the resident's room, revealed CNA #2 providing incontinence care to the resident. Continued observation revealed CNA #2 removed the wet brief, positioned resident on the side, performed incontinence care to the buttocks area using a non rinse solution, positioned the resident on the back, and provided incontinence care to the front area. Interview with RN #1 (registered nurse) on September 14, 2010, at 3:55 p.m., in the hallway, confirmed CNA #2 did not perform appropriate incontinence care. During the interview, RN #1 stated, "...are to clean the least dirty to the most dirty."	F 315	observations will be completed on all certified nursing assistants during the audit. All results will be reported monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to prevent a fall for one resident (#2) of eighteen residents reviewed.	F 323	F323 1. Resident #2 had an immediate audit of her care plan by the Director of Nursing to ensure that gait belt use was care planned for her care. Resident # 2 was assessed by a Registered Nurse upon incident, 08/10/2010 with no adverse outcomes. The Certified Nursing Assistant is no longer employed by the facility as of 8/10/10.	Completion Date 09/25/2010

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F 315	Continued From page 7 appropriate incontinence care had not been provided. Observation on September 14, 2010, at 3:30 p.m., in the resident's room, revealed CNA #2 providing incontinence care to the resident. Continued observation revealed CNA #2 removed the wet brief, positioned resident on the side, performed incontinence care to the buttocks area using a non rinse solution, positioned the resident on the back, and provided incontinence care to the front area. Interview with RN #1 (registered nurse) on September 14, 2010, at 3:55 p.m., in the hallway, confirmed CNA #2 did not perform appropriate incontinence care. During the interview, RN #1 stated, "...are to clean the least dirty to the most dirty."	F 315	2. An audit of all resident care plans was conducted by the Director of Nursing, Minimum Data Set Coordinator, and the Staffing Coordinator on 9/15/10 to assess for problem identification and appropriate intervention identification. 3. The Minimum Data Set Coordinator was inserviced about the care planning process by the Director of Nursing on 9/15/10. The Staffing Coordinator completed inservices with all certified nursing assistants and licensed nurses on 9/15/10, 9/17/10, and 9/23/10 regarding policies on gait belt use. 4. Completed admission, quarterly, significant change and annual assessments will be reviewed by the At risk committee weekly to ensure that their care plans are addressing needs of the resident appropriately. The At	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to prevent a fall for one resident (#2) of eighteen residents reviewed.	F 323		

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F 323	Continued From page 8 The findings included: Resident #2 was admitted to the facility on May 11, 2010, with diagnoses including Congestive Heart Failure, Diabetes, Aftercare for Fracture of Leg, Difficulty in Walking, and Esophageal Reflux. Medical record review of the Minimum Data Set dated August 7, 2010, revealed the resident had no deficit with memory, had modified independence for decision making, required extensive assist for transfers and ambulation. Review of the facility's documentation dated August 10, 2010, revealed the resident sustained a non-injury fall in the shower room. Continued review revealed CNA (certified nursing assistant) transferred the resident without using a gait belt. Interview with the DON (Director of Nursing) on September 15, 2010, at 1:15 p.m., in the DON's office, confirmed the CNA transferred the resident without using a gait belt. Continued interview revealed certified nursing assistants are to use a gait belt at all times during transfer of the residents.	F 323	risk committee is comprised of the Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, and Medicare Nurse. 100 % of completed quarterly and annual assessments will be reviewed weekly for four weeks then 25 completed care plans monthly for 3 months and/or 100% compliance. Gait belt use observations will be conducted randomly by the Staffing Coordinator on nursing assistants for a total of ten random observations for one week to ensure appropriate incontinence care is being provided. Then five random gait belt use observations on all three random shifts will be conducted each week for three months or until 100% compliance is achieved. Random observations will be completed on all certified	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 323	Continued From page 8 The findings included: Resident #2 was admitted to the facility on May 11, 2010, with diagnoses including Congestive Heart Failure, Diabetes, Aftercare for Fracture of Leg, Difficulty in Walking, and Esophageal Reflux. Medical record review of the Minimum Data Set dated August 7, 2010, revealed the resident had no deficit with memory, had modified independence for decision making, required extensive assist for transfers and ambulation. Review of the facility's documentation dated August 10, 2010, revealed the resident sustained a non-injury fall in the shower room. Continued review revealed CNA (certified nursing assistant) transferred the resident without using a gait belt. Interview with the DON (Director of Nursing) on September 15, 2010, at 1:15 p.m., in the DON's office, confirmed the CNA transferred the resident without using a gait belt. Continued interview revealed certified nursing assistants are to use a gait belt at all times during transfer of the residents.	F 323	nursing assistants during the audit. All results will be reported to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F431 1. The Aspirin and Kao-tin were immediately destroyed on 9/14/10 by LPN #1. The LPN was inserviced on 9/14/10 by the Director of Nursing on proper destruction of expired medications.	Completion Date 09/25/2010

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F 431	Continued From page 9 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure all medications provided in one of two medication carts available for resident use did not have expired use dates. The findings included: Observation with the licensed practical nurse (LPN #1), in the 300 hallway, of medications contained in the "300 hall" medication cart, on	F 431	2. All medications and medical supplies were audited by the Director of Nursing, Minimum Data Set Coordinator, Staffing Coordinator, and Medicare Nurse on 9/14/10 to ensure that all items had appropriate dates. No residents were identified as being affected by this. 3. The licensed nurses were inserviced on 9/21/10, 9/22/10, and 9/23/10 regarding procedures for appropriately dated medications and medical supplies by the Director of Nursing. 4. All medications and medical supplies will be monitored by the Director of Nursing daily for five days to ensure all medications provided in medication carts available for resident use does not have expired use dates. The medications and medical supplies will then be monitored by the Medicare Nurse Supervisor two times per week for three months or	

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F 431	Continued From page 10 September 14, 2010, at 8:30 a.m., revealed the following: 1) a bottle of Aspirin EC (enteric coated aspirin) 300mg, supplied with 100 tablets per container, had approximately 30 pills remaining with an expiration date of October 2009; and 2) Kao-tin (a medication for diarrhea), supplied in an 8 ounce bottle, had three-fourths of the liquid medication remaining, and an expiration date of October 2009. Interview with LPN #1, at the time of the observation, confirmed the two stock medications had been out of date for the previous eleven months.	F 431	until 100% compliance is achieved. All results will be reported monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F441 1. LPN #3 was immediately inserviced on 9/13/10 by the Director of Nursing regarding maintaining Infection Control standards during wound treatments. The wound for Resident # 7 was assessed by the Director of Nursing on 9/13/10 with no adverse affects noted. 2. Wound treatment observations were conducted by the	Completion Date 9/25/2010

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F 441	Continued From page 11 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on facility procedure review, observation, and interview the facility failed to ensure infection control strategies were maintained for one of one dressing change observed. The findings included: Review of the facility's Basic Infection Control Procedure for Wound Care revealed the stated purpose was, "To prevent cross-contamination among residents as well as between residents and caregivers." Review of the procedure revealed steps 2, 5 and 6 as follows, "2. Prepare clean field with necessary equipment...5. Remove soiled dressing...place in bag...Remove gloves and discard...6. Wash hands..." Observation on September 13, 2010, at 1:30 p.m., of licensed practical nurse (LPN #3), revealed the LPN preparing supplies outside of	F 441	Director of Nursing and a Registered Nurse on 9/14/10, 9/15/10, and 9/16/10 to observe for additional areas that may need to be addressed with proper infection control procedures. 3. The licensed nurses were inserviced on 9/21/10, 9/22/10, and 9/23/10 by the Director of Nursing regarding procedures for maintaining Infection Control standards during wound treatments. 4. Wound treatment observations will be conducted randomly to ensure proper infection control procedures for wound care are being used. The Director of Nursing and/or Staffing Coordinator will be observing wound treatment on Licensed Nurses for a total of ten random observations to include observations of every nurse for one week. Then five random wound treatment observations will be conducted each week for three months or until 100% compliance is achieved by the Staffing Coordinator. All results will be reported	

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F 441	Continued From page 12 Resident #7's room for a dressing change. Observation continued and revealed the following breaches in infection control practices: 1) the LPN dropped the tube of medication upon entering the room, retrieved it from the floor, and placed it back with the other clean supplies; 2) cleansed the ulcer with normal saline and removed the part of a previous dressing (still adhered to the right of the wound), and placed these items on the bed, a biohazard bag had not been brought to the room; 3) picked up the tube of medication with the same gloves worn to cleanse the ulcer, then put down, removed gloves, and began to don another pair of gloves without washing hands. Interview at the nursing station, on September 13, 2010, at 2:30 p.m., with the director of nursing (who had entered the room and observed the dressing change), verified infection control procedures had not been maintained.	F 441	monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure one of three types of blood tubes, used by the nursing staff when providing laboratory services and available to resident use, were within the expiration date.	F 502	F502 1. The lab tubes were immediately destroyed by LPN #4 on 9/14/10. LPN #4 was immediately inserviced on checking expired tubes by the Director of Nursing on 9/14/10. 2. All medications and medical supplies were audited by the Director of Nursing, Minimum Data Set Coordinator, Staffing Coordinator, and Medicare Nurse on 9/14/10 to ensure that all items had appropriate dates. 3. The licensed nursing staff was inserviced by the Director of Nursing on 9/21/10, 9/22/10, and 9/23/10 regarding procedures for appropriately dated medications and	Completion Date 9/25/2010

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F 502	Continued From page 13 The findings included: Observation on September 13, 2010, at 10:30 a.m., with the licensed practical nurse (LPN #4), in the medication room, of the three types of lab tubes used by the staff when drawing blood samples, revealed the "blue top" tubes had an expiration date of August 29, 2010. During interview, at the time of the observation, LPN #4 stated, "We go to the hospital and get the lab supplies to use..." Interview confirmed one of the three types of blood tubes used by the facility were outdated.	F 502	medical supplies. 4. All medications and medical supplies will be monitored by the Director of Nursing daily for five days to ensure all lab blood tubes used by the nursing staff when providing laboratory services and available to resident use, were within the expiration date. The medications and medical supplies will then be monitored by the Medicare Nurse Supervisor two times per week for three months or until 100% compliance is achieved. All results will be reported monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	